

# WELCOME TO OUR PRACTICE

## PATIENT INFORMATION...

Date \_\_\_\_\_

☐ Mr. ☐ Mrs. ☐ Ms. ☐ Dr. First Name \_\_\_\_\_ M.I. \_\_\_\_\_ Last Name \_\_\_\_\_ Nickname \_\_\_\_\_  
Sex: ☐ Male ☐ Female Birth Date \_\_\_\_\_ Age \_\_\_\_\_ Social Security Number \_\_\_\_\_  
Street \_\_\_\_\_ Apt. \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Home Tel. (\_\_\_\_\_) \_\_\_\_\_ Cell. (\_\_\_\_\_) \_\_\_\_\_ E-mail \_\_\_\_\_  
Did you find our practice online? ☐ Yes ☐ No Referred By \_\_\_\_\_  
Have you ever been a patient of our practice? ☐ Yes ☐ No Has a family member ever been a patient of our practice? ☐ Yes ☐ No  
Dentist \_\_\_\_\_ Medical Doctor \_\_\_\_\_  
Preferred Pharmacy \_\_\_\_\_ Tel. (\_\_\_\_\_) \_\_\_\_\_  
Driver's Lic.# \_\_\_\_\_ Nearest relative not living with you \_\_\_\_\_ Tel. (\_\_\_\_\_) \_\_\_\_\_  
Employer \_\_\_\_\_ Bus. Tel. (\_\_\_\_\_) \_\_\_\_\_ Personal Payment Type: ☐ Cash ☐ Check ☐ Credit Card  
In case of emergency, please contact \_\_\_\_\_ Tel. (\_\_\_\_\_) \_\_\_\_\_ Relation \_\_\_\_\_

## WHO WILL BE RESPONSIBLE FOR YOUR ACCOUNT...

☐ Self (If self, skip this section) ☐ Spouse ☐ Father ☐ Mother ☐ Other \_\_\_\_\_  
Name \_\_\_\_\_ S.S.# \_\_\_\_\_ Birth Date \_\_\_\_\_ Age \_\_\_\_\_ Tel. (\_\_\_\_\_) \_\_\_\_\_  
Street \_\_\_\_\_ Apt. \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Driver's Lic.# \_\_\_\_\_ Employer \_\_\_\_\_ Bus. Tel. (\_\_\_\_\_) \_\_\_\_\_

## SPOUSE OR OTHER GUARANTOR INFORMATION (if different from above)...

Name \_\_\_\_\_ Relation \_\_\_\_\_ S.S.# \_\_\_\_\_ Birth Date \_\_\_\_\_  
Street \_\_\_\_\_ Apt. \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Tel. (\_\_\_\_\_) \_\_\_\_\_ Employer \_\_\_\_\_ Bus. Tel. (\_\_\_\_\_) \_\_\_\_\_

## INSURANCE INFORMATION...

**Student:** ..... ☐ Full Time ☐ Part Time ☐ Not ..... School Name and Address \_\_\_\_\_  
**Marital Status:** ..... ☐ Married ☐ Divorced ☐ Widowed ☐ Single ☐ Legally Separated \_\_\_\_\_  
**Employed:** ..... ☐ Full Time ☐ Part Time ☐ Retired ☐ Not ..... Do you belong to a PPO or HMO? ☐ Yes ☐ No

## PRIMARY INSURANCE COMPANY...

**Insurance Type:** ☐ Dental ☐ Medical  
Employer \_\_\_\_\_  
Bus. Address \_\_\_\_\_  
Bus. Tel. (\_\_\_\_\_) \_\_\_\_\_ Plan \_\_\_\_\_  
Ins. Co. Name \_\_\_\_\_ I.D. # \_\_\_\_\_  
Address \_\_\_\_\_  
Tel. (\_\_\_\_\_) \_\_\_\_\_  
Group # \_\_\_\_\_ Group Name \_\_\_\_\_  
Insured Party \_\_\_\_\_ Relation \_\_\_\_\_  
Sex: ☐ M ☐ F Birth Date \_\_\_\_\_ S.S. # \_\_\_\_\_  
Street \_\_\_\_\_ City \_\_\_\_\_  
State, Zip \_\_\_\_\_ Tel. (\_\_\_\_\_) \_\_\_\_\_

## SECONDARY INSURANCE COMPANY...

**Insurance Type:** ☐ Dental ☐ Medical  
Employer \_\_\_\_\_  
Bus. Address \_\_\_\_\_  
Bus. Tel. (\_\_\_\_\_) \_\_\_\_\_ Plan \_\_\_\_\_  
Ins. Co. Name \_\_\_\_\_ I.D. # \_\_\_\_\_  
Address \_\_\_\_\_  
Tel. (\_\_\_\_\_) \_\_\_\_\_  
Group # \_\_\_\_\_ Group Name \_\_\_\_\_  
Insured Party \_\_\_\_\_ Relation \_\_\_\_\_  
Sex: ☐ M ☐ F Birth Date \_\_\_\_\_ S.S. # \_\_\_\_\_  
Street \_\_\_\_\_ City \_\_\_\_\_  
State, Zip \_\_\_\_\_ Tel. (\_\_\_\_\_) \_\_\_\_\_

## DENTAL INFORMATION...

Reason for today's visit \_\_\_\_\_ Are you in pain? ☐ Yes ☐ No, For How Long? \_\_\_\_\_

**Please indicate any of the following problems by checking off the corresponding box:**

- |  |   |  |  |
|--|---|--|--|
| <input type="checkbox"/> Discomfort, clicking, or popping in jaw   | <input type="checkbox"/> Lost / broken filling(s)   | <input type="checkbox"/> Stained teeth         | <input type="checkbox"/> Difficulty closing jaw    |
| <input type="checkbox"/> Red, swollen, or bleeding gums  | <input type="checkbox"/> Teeth grinding / clenching | <input type="checkbox"/> Locking jaw           | <input type="checkbox"/> Difficulty opening jaw    |
| <input type="checkbox"/> A removable dental appliance  | <input type="checkbox"/> Ringing in ears            | <input type="checkbox"/> Bad breath            | <input type="checkbox"/> Loose / shifting teeth    |
| <input type="checkbox"/> Blisters / sores in or around the mouth   | <input type="checkbox"/> Broken / chipped tooth     | <input type="checkbox"/> Burning tongue / lips | <input type="checkbox"/> Food caught between teeth |
| <input type="checkbox"/> Prolonged bleeding from an injury / extraction  | <input type="checkbox"/> Gum disease                | <input type="checkbox"/> Toothache             | <input type="checkbox"/> Swelling / lumps in mouth |
| <input type="checkbox"/> Recent infections or sore throat  | <input type="checkbox"/> Other _____                |  |  |
| <input type="checkbox"/> My teeth are sensitive to: <input type="checkbox"/> Hot <input type="checkbox"/> Cold |   |  |  |
| <input type="checkbox"/> Sweets <input type="checkbox"/> Biting  |   |  |  |

Last dental exam \_\_\_\_\_ Last dental x-rays \_\_\_\_\_ Times a day you brush? \_\_\_\_\_ Times a week you floss? \_\_\_\_\_  
How would you rate your smile? (worst) 1 2 3 4 5 6 7 8 9 10 (best) Would you like whiter teeth? ☐ Yes ☐ No  
What type of toothbrush bristles do you use? ☐ Soft ☐ Medium ☐ Hard

## MEDICAL HISTORY...

Are you in good health? ☐ Yes ☐ No • Height \_\_\_\_\_ Weight \_\_\_\_\_ • Are you under the care of a physician? ☐ Yes ☐ No  
 Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment? ☐ Yes ☐ No  
 Have you had any illness, operation, or been hospitalized in the past five years? ☐ Yes ☐ No  
 Have you ever had general anesthesia? ☐ Yes ☐ No • Have you, or a family member, had any unusual or serious reactions to general anesthesia? ☐ Yes ☐ No

### Do you have, or have you had, any of the following diseases, medical conditions, or procedures?

- |   |  |   |  |
|---|--|---|--|
| <b>Y N</b>  | <b>Y N</b>   | <b>Y N</b>  | <b>Y N</b>   |
| <input type="checkbox"/> Rheumatic fever                        | <input type="checkbox"/> Mental health problems      | <input type="checkbox"/> Abnormal bleeding        | <input type="checkbox"/> Kidney trouble                    |
| <input type="checkbox"/> High blood pressure                    | <input type="checkbox"/> Problems with immune system | <input type="checkbox"/> Bleeding tendency        | <input type="checkbox"/> Sexually transmitted diseases     |
| <input type="checkbox"/> Low blood pressure                     | <i>(possibly from med. / surg.)</i>                  | <input type="checkbox"/> Blood transfusion        | <input type="checkbox"/> Contagious diseases               |
| <input type="checkbox"/> Mitral valve prolapse                  | <input type="checkbox"/> Delay in healing            | <input type="checkbox"/> Blood disorder           | <input type="checkbox"/> Infectious mononucleosis          |
| <input type="checkbox"/> Heart murmur                           | <input type="checkbox"/> Hay fever / Sinus problems  | <input type="checkbox"/> Bruise easily            | <input type="checkbox"/> Swollen ankles                    |
| <input type="checkbox"/> Chest pain / Angina                    | <input type="checkbox"/> Snoring                     | <input type="checkbox"/> Eye disease / Glaucoma   | <input type="checkbox"/> Arthritis / Joint disease         |
| <input type="checkbox"/> Heart attack(s)                        | <input type="checkbox"/> Sleep apnea / CPAP          | <input type="checkbox"/> Jaundice / Liver disease | <input type="checkbox"/> Prosthetic implant                |
| <input type="checkbox"/> Irregular heart beat                   | <input type="checkbox"/> Respiratory problems        | <input type="checkbox"/> Hepatitis                | <input type="checkbox"/> Joint replacement                 |
| <input type="checkbox"/> Cardiac pacemaker                      | <input type="checkbox"/> Tuberculosis                | <input type="checkbox"/> Gallbladder trouble      | <input type="checkbox"/> Osteoporosis / Osteopenia         |
| <input type="checkbox"/> Heart surgery                          | <input type="checkbox"/> Emphysema                   | <input type="checkbox"/> Fainting spells          | <input type="checkbox"/> Osteonecrosis                     |
| <input type="checkbox"/> Damaged heart valves                   | <input type="checkbox"/> Do you smoke or vape?       | <input type="checkbox"/> Convulsions / Epilepsy   | <input type="checkbox"/> Stomach ulcers / Acid reflux      |
| <input type="checkbox"/> Pneumonia / Bronchitis / Chronic cough | <i>If so, how much a day _____</i>                   | <input type="checkbox"/> Stroke                   | <input type="checkbox"/> GI troubles / IBS / Colitis       |
| <input type="checkbox"/> Chronic fatigue / Night sweat          | <input type="checkbox"/> Do you use chewing tobacco  | <input type="checkbox"/> Thyroid trouble          | <input type="checkbox"/> Tumor or growth                   |
| <input type="checkbox"/> Trouble climbing 1-2 flights of stairs | <input type="checkbox"/> A history of marijuana or   | <input type="checkbox"/> Diabetes                 | <input type="checkbox"/> Cancer / Radiation / Chemotherapy |
| <input type="checkbox"/> Anemia                                 | other drug use                                       | <input type="checkbox"/> Low blood sugar          | <input type="checkbox"/> Are you on a diet                 |
| <input type="checkbox"/> Asthma                                 | <input type="checkbox"/> A history of alcohol abuse  | <input type="checkbox"/> Are you on dialysis      | <input type="checkbox"/> Contact lenses                    |

## MEDICATION & ALLERGIES...

### Are you now taking:

- |                                      |   |  |
|--------------------------------------|---|--|
| <b>Y N</b>                           | <b>Y N</b>  | <b>Y N</b>                               |
| <input type="checkbox"/> Nerve pills | <input type="checkbox"/> Pain killers (including aspirin) | <input type="checkbox"/> Muscle relaxers |
| <input type="checkbox"/> Diet pills  | <input type="checkbox"/> Tranquilizers                    | <input type="checkbox"/> Insulin         |

### Please list any other medication(s) you are taking (including natural, herbal, or homeopathic products):

MEDICATION	DOSAGE	FREQUENCY	MEDICATION	DOSAGE	FREQUENCY	MEDICATION	DOSAGE	FREQUENCY

### Are you allergic to, or had a reaction to:

- |   |                                      |   |  |
|---|--------------------------------------|---|--|
| <b>Y N</b>  | <b>Y N</b>                           | <b>Y N</b>  | <b>Y N</b>   |
| <input type="checkbox"/> Penicillin                               | <input type="checkbox"/> Sulfa drugs | <input type="checkbox"/> Local anesthetic (numbing med) | <input type="checkbox"/> Amoxicillin                     |
| <input type="checkbox"/> Sodium pentothal / Valium / other tranq. | <input type="checkbox"/> Aspirin     | <input type="checkbox"/> Codeine or other narcotics     | <input type="checkbox"/> Latex                           |
| <input type="checkbox"/> Soy                                      | <input type="checkbox"/> Eggs / Yolk | <input type="checkbox"/> Sulfites                       | <input type="checkbox"/> Do you have any known allergies |

Please list any other medication or antibiotic you are allergic to: \_\_\_\_\_

Please list any allergies other than drug allergies: \_\_\_\_\_

**1-4 below for women only:** (Women note: antibiotics (such as penicillin) may alter the effectiveness of birth control pills. Consult your physician / gynecologist for assistance regarding additional methods of birth control.)

- |   |  |
|---|--|
| <b>1)</b> Is there a possibility of pregnancy? <input type="checkbox"/> Yes <input type="checkbox"/> No | <b>2)</b> Expected delivery date: _____  |
| <b>3)</b> Are you nursing? <input type="checkbox"/> Yes <input type="checkbox"/> No                     | <b>4)</b> Are you taking birth control pills: <input type="checkbox"/> Yes <input type="checkbox"/> No |

I certify that I have read and I understand the questions above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my doctor, or any other member of his / her staff, responsible for any errors or omissions that I have made in the completion of this form.

<b>X</b> _____	<b>X</b> _____	<b>X</b> _____
Signature of patient (Parent or Guardian if Minor)	Reviewed by	Date

## FEES & PAYMENTS

We make every effort to keep down the cost of your care. You can help by paying upon completion of each visit. Other arrangements can be made with our office manager depending upon special circumstances. An estimate of the charge for any procedure or surgery you may require will be given to you upon request. If you have any dental and/or medical insurance we will be glad to fill out the proper forms, but please complete the identifying information on this form.

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures and others pay a percentage of the charge. **It is your responsibility to pay any deductible amount, co-insurance or any other balance not paid for by your insurance company.** You will be responsible for all collection costs, attorneys fees, and court costs.

☐ I permit the office to communicate with me via text message on my cell phone.

<b>X</b> _____	<b>X</b> _____
Signature of patient (Parent or Guardian if Minor)	Date

This signature on file is my authorization for the release of information necessary to process my claim. I hereby authorize payment to this doctor named of the benefits otherwise payable to me.

<b>X</b> _____	<b>X</b> _____
Signature of patient (Parent or Guardian if Minor)	Date

I hereby acknowledge that a copy of this office's Notice of Privacy Practices has been made available to me. I have been given the opportunity to ask any questions I may have regarding this Notice.

<b>X</b> _____	<b>X</b> _____
Signature of patient (Parent or Guardian if Minor)	Date

## **Elite Dental Office Guidelines**

### **Patient Financial Policy**

***Our Policy*** requires payment at the time of service for your visit.

***For our patients***, we will give a 5% Courtesy Discount on fees over \$500 that are paid in full *prior* to the day of service with cash or check (does not apply to insurance co-payments)

If you are a member of a Dental Insurance Plan and have chosen us as a provider of care, it is your responsibility to:

- Pay your deductible and estimated portion at the time of service
- Pay for the services not covered by your insurance carrier
- Provide us with information relative to your claim, including:
  - Insurance card and Picture ID
  - Primary Policy Holders Information
  - Social Security number, Birth date, Employer
  - Correct Address

**Insurance Claims for your carriers are filed as a courtesy at no charge to you.**

Please remember that all treatment plans given are an ***estimate*** based upon the most current information received from your insurance company. Amounts and Co-pays are subject to change on receipt of Explanation of Benefits. Patient/Responsible Party is responsible for any and all balances which may remain and are to be paid in a timely manner.

- To assist you with your payment, our office accepts Cash, Visa, Master card, and American Express.
- We have made special arrangements with **Care Credit** to provide extended payment plans with zero interest rates for six (6) months. Applications are available from Front desk staff and a quick approval can be made.

When your bill is unpaid, a collection agency may be chosen to manage delinquent accounts. If your account is placed with a collection agency, you will be responsible for all costs of collection.

### **Cancellation/Broken Appointment Policy**

We respect the importance of your time, and work very hard to schedule appointments that accommodate the busy scheduling needs of our patients. In return, we ask that all patients make every effort not to change reserved dental appointments.

If you must change a scheduled appointment, we require a minimum of 48 hours notice, so that we may accommodate another patient.

Patients who fail to come for scheduled appointments will be charged a broken appointment fee of \$60.00. For appointments more than one hour, the fee will be 10% of the scheduled appointment charges.

Thank you for your cooperation in this matter.

***I have read and fully understand my financial responsibilities under this policy:***

Sign \_\_\_\_\_

Date \_\_\_\_\_